MDR Tracking Number: M5-05-1933-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 03-11-05.

CPT code 97546-WC date of service 08-27-04 and CPT code 99080-69 date of service 10-04-04 were withdrawn by the requestor on 03-30-05 and will not be part of this review.

The IRO reviewed chiropractic manipulation, therapeutic exercises, therapeutic activities and telephone call rendered from 07-12-04 through 09-30-04 that were denied based upon "V".

The IRO determined that the chiropractic manipulation treatments **were** medically necessary and all other treatments and procedures **were not** medically necessary. The amount of reimbursement due from the carrier equals **$903.00.**

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 04-01-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99371 date of service 05-13-04 denied with denial code "G" (global). This service is not a separate fee it is always bundled. No reimbursement recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees for dates of service 07-12-04 through 09-28-04 totaling $903.00 in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Findings and Decision and Order are hereby issued this 2nd day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-1933-01
Name of Patient:	
Name of URA/Payer:	Jack P. Mitchell, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Jack P. Mitchell, DC

April 19, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records by the provider
2. EOBs
3. FCE
4. Diagnostic imaging reports
5. Report from Renato Bosita, M.D.
6. Correspondence from carrier
7. Carrier review

Patient underwent physical medicine treatments, FCE, and diagnostic imaging after sustaining injury to her lumbar spine on ___ while on the job at UPS. The claimant first consulted with the provider on 05/12/04.

REQUESTED SERVICE(S)

98941 Chiropractic Manipulation, 97110 Therapeutic Exercises, 97530 Therapeutic Activities, and 99371 Telephone Call from 07/12/04 through 09/30/04.

DECISION

All chiropractic manipulation treatments (98941) are approved.

All other treatments and procedures are denied.

RATIONALE/BASIS FOR DECISION

According to the AHCPR[1] guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. JMPT [2] reported that spinal manipulation may be the only treatment modality offering broad and significant long-term benefit for patients with chronic spinal pain syndromes. Based on those findings and statutory requirements [3] for medical necessity, the chiropractic manipulation treatments performed during the time frame in question were both indicated and medically necessary.

No treatment records were available for review during the time period immediately preceding the treatment in question. Therefore, it is unknown what kinds of therapies and/or treatments had been attempted, what was beneficial and what was not, and were the disputed treatments different or more of the same. Without medical treatment records that answer those questions, there is less than sufficient documentation to support the medical necessity of the disputed therapeutic exercises and activities.

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[1] Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

[2] Muller, R. Giles, G.F. J Manipulative Physiol Ther 2005;28:3-11.

[3] Texas Labor Code 408.021

In regard to rehabilitative exercises, they may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why the services were required to be performed one-on-one when current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises." [4]

Services that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary services even if the services are performed by a health care provider. In this case, the patient would have been very familiar with the exercises and would have been able to perform them without one-on-one assistance thus making them medically unnecessary.

[4] Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.